CMS
CENTERS for MEDICARE & MEDICAID SERVICES

M+C RISK ADJUSTMENT PUBLIC MEETING

COLLECTION & SUBMISSION OF DIAGNOSTIC INFORMATION

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Encounter Data Submission

- Commenced in 1998 with hospital inpatient data to run PIP-DCG model
- Added ambulatory data collection
  - physician encounter data commenced in late 2000
  - hospital outpatient encounter data commenced April 2001
- Secretary suspended requirements for ambulatory data submission from May 2001 until July 2002

Data Requirements - Before

- Based on fee-for-service claims formats
- Collected data to support model maintenance and data verification
- All encounter data elements were edited
- Non-risk adjustment elements could cause errors
- Errors on elements not directly related to risk adjustment needed to be corrected for diagnoses to be accepted

Encounter Data Process - Before

- 3-4 stages of editing
  - Front-end processor
  - Medicare Code Editor/Outpatient Code Editor (hospital data only)
  - Claims processing system
  - Common Working File (CWF)
- Data could fail at any stage in process
- Files broken into individual encounters

M+CO Burden: Issues

- Number of transactions M+COs are required to submit
- Number of data elements per transaction
- Number of edits that require correction and re-submission of transactions
- Fragmentation in editing and reporting

New Submission Format and Processing System

- Will be utilized for M+CO submission and CMS processing of all future risk adjustment data
- Will begin processing ambulatory data in October 2002, for diagnoses from July 1, 2002 forward
- Inpatient data for 2003 payments and for 2002 reconciliation must go through the existing processing systems (submission deadline remains September 2002)

New Data Submission

- Simplified format, fewer data elements
  - Beneficiary identifier (HIC number)
  - Diagnosis
  - From/through dates
  - Provider type (hospital inpatient, hospital outpatient, physician)
  - Control number (optional)

New Data Submission (cont'd)

- Reduced submission frequency - option of once per quarter rather than monthly
- Diagnosis reported once per member in a given data collection period
- One record can have multiple provider types (hospital inpatient, outpatient, and physician)
- One exception - late data for 2003 must be submitted as "encounter data" under existing formats (i.e., UB-92, ANSI X12 837)

More Options for Submission

- Continue to submit using existing formats (must be done for 2003 reconciliation)
  - UB-92/NSF
  - ANSI X12 837
- Send reduced format
- On-line direct data entry
- Regardless of submission method, data will be subjected to reduced set of edits

Simplified Processing

- Front-end performs file-level editing only
  - Verify record counts
  - Header/trailer information correct
- Single processing system edits all elements
- All edits performed, regardless of number of edit failures

Simplified Reporting

- One report listing all transactions and status
- Report will tell which diagnoses are accepted for risk adjustment and which were not (with reason why not)
- Report should always be available within 2-3 working days of submission
- Ultimate goal is complete report the next day

Improved Data Tracking

- Reporting complete results immediately eliminates need to track one submission for several weeks or months
- M+COs should provide some form of internal control number similar to the patient control number on encounters
- CMS will provide a control number for each transaction and each record in a transaction

Input from M+COs Needed

- How to format transaction status reports to meet M+CO needs
- What information is required to allow M+COs to match transaction replies with submitted transactions
- How to assist M+COs in data collection from capitated providers - possibility of a superbill of diagnoses

Elimination of Lag

- Lag is the period between collection of diagnostic data and payments made under the risk adjustment model
- Currently, PIP-DCG risk factors are based on diagnoses that are lagged by six months
  - Example: Dx from 7/00 - 6/01 are used to determine the risk factor for use in 2002

Elimination of Lag (cont'd)

- Initial implementation of new model in 2004 will incorporate lag
- Initial 2004 risk factor will be based on diagnoses from 07/02 - 06/03, with data due by end of September 2003
- CMS proposes to eliminate lag in early 2004

Elimination of Lag (cont'd)

- Deadline for diagnoses from calendar year 2003 would be end of March 2004
- Early reconciliation of calendar year 2004 with new 2004 factor
- Future deadlines need to be discussed, i.e., should we have two factors every year or use the old year factor for the first half of the next calendar year

Improved Data Collection from M+CO Provider Networks

- Two principal network payment arrangements, fee-for-service and capitation
- Generally, fee-for-service arrangements collect data from networks using standard claims formats
- Capitated arrangements may use different, non-standard formats to collect data for submission

Data Collection for M+COs with Fee-for-Service Networks

- Continue collecting data from network providers using same claim formats
- M+CO should develop data submission process that utilizes data collected on these fee-for service bills
- M+COs can choose to submit the bills
- Fewer edits and fewer submissions require fewer provider data corrections

Data Collection for M+COs with Capitated Networks

- Reduced data formats and less frequent submission can benefit M+COs with capitated or mixed networks
- CMS will provide electronic file linking ICD-9 codes and labels for diagnoses in the model
- Physicians or M+COs could develop superbill from publicly available file

HIPAA and Risk Adjustment Data Collection/Submission

- HIPAA claim transaction applies to electronic claims and encounter data submitted by providers to health plans
- Hospitals and physicians are providers
- M+COs and CMS are health plans
- HIPAA claims standard does not apply to data exchanged between M+COs and CMS, but CMS will accept HIPAA claims standard from compliant M+COs

HIPAA and Risk Adjustment Data (cont'd)

- If M+CO has fee-for-service network and collects data electronically, must utilize HIPAA standard by October 2003 and shall not re-request any data on the claim in any other format
- If M+CO has capitated network and collects beneficiary summary record, not clear that HIPAA will apply

Alternative Data Sources (ADS)

- Some M+COs suggested using alternative data sources for risk adjustment process
- ADS includes pharmacy or disease management data
- Two Potential Uses:
  - As a check to ensure all diagnoses submitted
  - As an alternative to diagnoses from providers

Concerns with Use of ADS as an Alternative to Diagnoses

- There are few direct connections between diseases and ADS (e.g., insulin for diabetes)
- ADS are not consistently endorsed by M+COs - some perceive as inequitable
- CMS cannot estimate accurate payments using ADS

Supporting Documentation

- CMS will continue to require supporting medical record documentation upon request for risk adjustment data
- M+COs will need to continue to follow ICD-9 coding guidelines and code to highest level of specificity
- CMS will validate inpatient and ambulatory diagnoses

Supporting Documentation (cont'd)

- CMS request for supporting documentation will include only the limited set of data submitted to CMS
- M+COs need to maintain information necessary to link diagnoses back to a specific hospital or physician
- Less data required on submission requires careful data maintenance on part of M+CO to link data to source

Risk Adjustment Data Submission Regional Training

- Focus of training sessions
  - Changes in collection and reporting of diagnostic data
  - Technical requirements
  - Risk Adjustment
- Will occur late Spring 2002 (May/June)
- Will be in 4 regional areas
- Sessions are expected to be 1 day

Risk Adjustment Data Submission Training

- Continue Monthly User Group Sessions
- Specialized User Group Sessions as needed (e.g. “Back to Basics”)
- Train-the-trainer sessions for physician coding and submission guidance

Risk Adjustment Onsite Visits and Technical Assistance

- Continue to offer onsite visits to improve the quality of diagnostic information
- Provide technical assistance to M+COs that have data submission problems
- On-site visits are always voluntary
- CMS identifies M+COs that may need assistance and offers on-site visits or conference calls, as appropriate
- M+COs may request an onsite visit/call

Proposed Schedule

- January 2002 - develop reply formats working with M+COs
- April 2002 - release draft OPL
- May/June 2002 - regional training
- July 2002 - effective date for risk adjustment data
- September 2002 - inpatient deadlines
- October 2002 - M+COs submit data to new system (inpatient and ambulatory)